New Team Member Orientation

Veronica Richardson
IHI National Collaborative Director, BPHC Health Disparities Collaboratives
Items to be discussed:

- What is the collaborative process or the “Learning Model”?
- The Chronic Care Model
  - Components
  - Interrelationships
- The Model for Improvement
  - 3 questions: Aims, measures, tests of change
  - PDSA cycles
The Breakthrough Series
(Learning Model)

An improvement method that relies on **spread and adaptation** of **existing knowledge** to **multiple settings** to accomplish a common aim.

BTS is not:
- Research for new knowledge
- Single-setting (team) focus
- Small changes to existing systems
- Benchmarking project

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Breakthrough Series Premises

- There are gaps between knowledge and practice.
- There are large variations in practices.
- “Best practices” exist all over the world.
- All improvement requires change, but not all change leads to improvement.
- Every system is perfectly designed to achieve the results it achieves.
- We can learn a lot more working together than we can working separately.
Learning Model
(adapted from the IHI breakthrough series)

Select Topic

Expert Panel

Planning Group

Participants apply and are selected

Pre-work

Identify Change Concepts

Time for setting aims, allocating resources, preparing baseline data leading to the first 2 day meeting.

LS 1

Action period 1: Adapt and test the ideas for improved system of care

LS 2

Action period 2: Further develop the system of care at the pilot site and spread the system to other sites &/or practitioners

LS 3

National Congress and Spread

Supports

E-mail Conference Calls Assessments Senior Leader Reports Site Visits List Serv
Phase 1

1. Select Topic
2. Planning Group
   - Identify Change Concepts
   - Pre-work

Phase 2

1. Sustain and Spread
2. Continued reporting and progress toward national goals
3. Integration of models into the organizational structure
4. Increasing registry size
5. Continued support and interaction
...And going
Fundamental Elements for Success

- Will (to change the system)

- Knowledge (of the gap and what changes are necessary to close it)

- Execution (actions that close the gap)
Fundamental Elements for Success

- Will (to change the system)

- Knowledge (of the gap and what changes are necessary to close it)

- Execution (actions that close the gap)
Chronic Care Model

“The model of care is a population-based model that relies on knowing which patients have the illness, assuring that they receive evidence-based care and actively aiding them to participate in their own care.”
System Change Concepts
Why a Chronic Care Model?

- Emphasis on physician, not system, behavior
- Characteristics of successful interventions weren’t being categorized usefully
- Commonalities across chronic conditions unappreciated.
Model Development 1993

- Initial experience at GHC
- Literature review
- RWJF Chronic Illness Meeting -- Seattle
- Review and revision by advisory committee (40 members (32 active participants)
- Interviews and site visits with 72 nominated “best practices”
- Model applied with diabetes, geriatrics, asthma, CHF, CVD, and depression with over 500 health care organizations in national and regional collaboratives
Improved Outcomes
Essential Elements of Good Chronic Illness Care

Informed, Activated Patient  →  Productive Interactions  ←  Prepared Practice Team
What characterizes a “prepared” practice team?

At the time of the visit, they have the patient information, decision support, people, equipment, and time required to deliver evidence-based clinical management and self-management support...and going
What characterizes a “informed, activated” patient?

Informed, Activated Patient

Patient understands the disease process, and realizes his/her role as the daily self manager. Family and caregivers are engaged in the patient’s self-management. The provider is viewed as a guide on the side, not the sage on the stage!
Designing Our Strategic Plan
The Care Model - A Systems Approach

1. Community Resources and Policies
   - Self-Management Support
2. Health System
   - Health Care Organization
     - Delivery System Design
     - Decision Support
     - Clinical Information Systems
3. Prepared, Proactive Practice Team
4. Productive Interactions
5. Informed, Activated Patient/Family

*Adapted from: Improving Chronic Illness Care, a national program of the Robert Wood Johnson Foundation
www.improvingchroniccare.org*

*Functional and Clinical Outcomes*
Health Care Organization

- Include measurable goals for chronic illness in the business plan.
- Senior leaders visibly support improvement in chronic illness care.
- Use effective improvement strategies aimed at comprehensive system change.
- Promote good chronic illness care through benefit packages.
- Encourage better chronic illness care through provider incentives.
Community Resources and Policies

- Identify effective programs and encourage patients to participate.
- Form partnerships with community organizations to support or develop evidence-based programs.
Self-management Support

- Emphasize the patient's central role in managing their illness.
- Assess patient self-management knowledge, behaviors, confidence, and barriers.
- Provide effective behavior change interventions and ongoing support with peers or professionals.
- Assure collaborative care-planning and problem-solving by the team.
Delivery System Design

- Define roles and delegate tasks amongst team members.
- Use planned visits to support evidence-based care.
- Build “effective” case management functionality into practice
- Assure continuity by the primary care team.
- Assure regular follow-up.
Decision Support

- Embed evidence-based guidelines which describe stepped-care into daily clinical practice.
- Integrate specialist expertise into primary care.
- Use proven provider education modalities to support behavior change.
- Inform patients about guidelines pertinent to their care.
Clinical Information System

- Include clinically useful and timely information on all patients in a registry.
- Provide reminders and feedback for providers and patients.
- Identify relevant patient subgroups and provide proactive care.
- Facilitate individual patient care planning through the registry.
Health System
Organization of Health Care
Strategic Plan/ Senior leadership support

Community
Resources and Policies
Partnerships
Coordination

Self-Mgt Support
Delivery System Design
Clinical Information Systems
Decision support

Care planning and problem solving
Planned Visits
Registry
Provider education
Evidence-based Guidelines
Specialist Expertise

… and going
Change Concepts

General ideas that have been found to be useful in developing specific improvement activities. Best if based on evidence.

e.g., All patients with asthma should have severity regularly assessed
Fundamental Elements for Success

- Will (to change the system)
- Knowledge (of the gap and what changes are necessary to close it)
- **Execution** (actions that close the gap)
Let’s Put it into Practice!
Why test?

Act
Plan
Study
Do

...and going
What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?

Model for Improvement

<table>
<thead>
<tr>
<th>Act</th>
<th>Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Study</td>
<td>Do</td>
</tr>
</tbody>
</table>

Tools you already have...

• Goals that define excellent practice; Care Model
• Description of Key Measures
• Change Concepts and Ideas organized by elements of the Care Model

The PDSA cycle provides the means to apply, adapt and implement the change concepts in your practice.
What is the PDSA Cycle?

**Act**
- What changes are to be made?
- Next cycle?

**Plan**
- Objective
- Questions and predictions (why)
- Plan to carry out the cycle (who, what, where, when)

**Study**
- Complete the analysis of the data
- Compare data to predictions
- Summarize what was learned

**Do**
- Carry out the plan
- Document problems and unexpected observations
- Begin analysis of the data
Testing on a Small Scale

- Test the change on the members of the team that helped developed it before introducing the change to others.
- Incorporate redundancy in the test by making the change side-by-side with the existing system.
- Conduct the test in one facility or office in the organization, or with one patient.
- Conduct the test over a short time period.
- Test the change on a small group of volunteers.
Testing a Change

- Increase your belief that the change will result in improvement in your organization.
- Opportunity for “failures” without impacting performance.
- Document how much improvement can be expected from the change.
- Learn how to adapt the change to conditions in the local environment.
- Evaluate costs and side-effects of the change.
- Minimize resistance upon implementation.
Aim: Increase the number of patients having severity assessed by incorporating the use of a national standards-based flowsheet

Use of flowsheet will improve care to known standards

90% of patients have severity assessment in record

Cycle 1A: Adapt flowsheet and test with one of Joanne’s patients
Cycle 1B: Revise flowsheet and test with all of Dr. Burton’s asthmatic patients next Monday
Cycle 1C: Present refined flowsheet to all 3 clinicians and document feedback
Cycle 1D: Revise and test flowsheet with all patients for one week
Cycle 1E: Implement and monitor the standards
Do Study

- **Reasons for failed tests**
  1. Change not planned and/or executed well
  2. Support processes inadequate
  3. Hypothesis/hunch wrong:
     - Change executed, well but did not result in local improvement
     - Local improvement did not impact the component of the CCM

- Collect **data** during the Do Phase of the Cycle to help differentiate the these situations.
To Be Considered a PDSA Cycle

- The test or observation was planned (including a plan for collecting data).
- The plan was attempted.
- Time was set aside to analyze the data and study the results.
- Action was rationally based on what was learned.
Repeated Use of the Cycle

Hunches
Theories
Ideas

Changes That Result in Improvement

DATA

Hunches
Theories
Ideas
Overall Aim: Implement the Care Model for people with asthma

Strategies for Each Component of the Care Model
Population of Focus

- Narrative and numerical description
- Naturally defined population with normal growth (recommend 100-300)
- Example: “The POF is all of the patients seen by Dr. Good in 1999 with a diagnosis of diabetes. This will be approximately 155 patients.”
Suggestions for Measurement and Data Collection During PDSA Cycles

- Collect useful data, not perfect data. The purpose of the data is learning, not evaluation.
- Use a pencil and paper until the information system is ready.
- Use qualitative data rather than wait for quantitative.
- Record what went wrong during the data collection.
How will we know that a change is an improvement?

A collaborative is about changing a participating organization’s approach to the topic of the collaborative

It is not about measurement. But ……

• Data base management and measurement are key components of the Care Model.
• Key outcome measures are required to assess progress on a team’s aim.
• Specific measures are required for learning about the components of the Care Model.
Proportion of men age 35 or older, and women age 45 or older who have had a Lipid profile within the last five (5) years.

- Development of registry
- Reminder system tested and refined
- Receptionist doing F/U calls
- Case manager responsible for follow-up

Minimum Standard for Monthly Reporting in the Collaborative: Annotated Time Series
What happened to this Clinic?

Average Symptom-Free Days (out of last 14)
Does this help explain?

Number of Asthma Patients in the Registry

Number of pts

S-01 O-01 N-01 D-01 J-02 F-02 M-02 A-02 M-02 J-02 J-02 A-02 S-02 O-02 N-02 D-02 J-03 F-03 M-03 A-03
Average Symptom-Free Days (out of last 14)

What happened to this Clinic?

Increase in registry size from 50 to 145
Cycles for Implementation

- The change is permanent - need to develop all support processes to maintain change.
- Learning is focused on integrating the change into the specific environment.
- High expectation to see improvement (no failures).
- Increased scope will lead to increased resistance.
- Generally takes more time than test cycles.
<table>
<thead>
<tr>
<th>1. What are we trying to accomplish?</th>
<th>To have each member of the team touch the ball in sequence</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Measures of performance</td>
<td>(a) Time to complete the cycle (faster is better)</td>
</tr>
<tr>
<td></td>
<td>(b) How many times the ball hits the floor (zero is ideal)</td>
</tr>
<tr>
<td>3. What change can we make that will lead to improvement?</td>
<td>To be determined by group</td>
</tr>
</tbody>
</table>
What are we trying to accomplish?

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Model for Improvement

Act

Plan

Study

Do
Report Components

- Aim
- Population of Focus/Spread
- Measures
- Description of tests of change/implemented changes
- Summary
- Assessment score
Use of Report

- Communication Tool - senior leaders, BOD, staff and community linkages
- Guidance for team
- Accrediting bodies (ie, JCAHO)
- Director/IS feedback
- Impact of tests and implemented change
Health Care for the Homeless Clinicians’ Network

Laura Gillis, MS, RN
HCH Collaboratives Coordinator
Health Care for the Homeless Clinicians’ Network
www.nhchc.org

Jennie McLaurin, MD
MCN Collaborative Director
Migrant Clinicians Network
Migrantcliniciansnetwork.org